SCREENING FORM
ALABAMA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (ABCCEDP)

Tracking Number (required)

PERSONAL DATA

Name: _____ Date of Birth: _____

Address: _____

_____ Day Phone: _____

Social Security Number: _____ Today's Date: _____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic Referral Source: ❑ Self ❑ Other ❑ Provider ❑ Outreach ❑ ABCCEDP reminder

Race (Check all that apply): ❑ White ❑ Black/African American ❑ Asian ❑ Native Hawaiian/Other Pacific Islander

❑ American Indian/Alaskan Native ❑ Asian/Pacific Islander ❑ Unknown Smoker? ❑ Yes (Refer Hot Line 1-800-784-8669)

Patient's Annual Household Income before Taxes: _____ Number of People Living on the Income: _____

BREAST SCREENING DATA

Check here if this is a family planning woman: ❑ Yes

Clinic/Provider: _____ **Prior Mammogram?** ❑ Yes, Date: _____ ❑ No

CBE Results:
Date of CBE: _____
- ❑ **Normal** ❑ **CBE Not Done**
- ❑ **Benign findings,** NOT suspicious for cancer
- ❑ ***Discrete palpable mass,** suspicious for cancer
- ❑ ***Bloody or serous nipple discharge** (not green, black, or white)
- ❑ ***Nipple or areolar scaliness**
- ❑ ***Skin dimpling or retraction**

***Requires surgeon referral or ultrasound** (use ABCCEDP Breast Diagnostic and Follow-Up Form)

Indication for initial mammogram:
- ❑ Screening
- ❑ Diagnostic
- ❑ No mammogram
- ❑ Non program mammogram, referred in for diagnostic evaluation;

Breast Diagnostic referral date: _____

Mammogram result (non-program funded): _____

Risk for breast cancer: (Risk Score: _____%)
- ❑ Average risk
- ❑ High /Increased risk** (If yes, check all that apply):
  - ❑ Women with genetic mutation such as BRCA mutation
  - ❑ Has a first degree relative (ex: mother, sister, daughter) who is BRCA carrier
  - ❑ Had radiation treatment to the chest area before the age of 30
  - ❑ Personal history of lobular carcinoma in situ
  - ❑ Patient has unusual circumstances to be approved by the Medical Advisory Committee

Surgical Consult to: _____ **Appt. Date:** _____

**Patient may qualify for screening MRI. Prior authorization required to order MRI. Contact your Regional Coordinator for MRI prior approval; Use Breast MRI Authorization and Results Form. The risk factors constitute a >20% breast risk assessment score. ANY model can be used, for example, (www.cancer.gov/bcrisktool, https://ibis-risk-calculator.magview.com/)

CERVICAL SCREENING DATA

Check here if this is a family planning woman: ❑ Yes

Clinic/Provider: _____

Prior Pap Smear: ❑ Yes, Date: _____ ❑ No ❑ Unknown

Bilateral Tubal Ligation? ❑ Yes ❑ No

Hysterectomy? ❑ Yes, Date: _____ ❑ No

Reason ❑ Cervical Cancer ❑ Other

Cervix Present? ❑ Yes ❑ No

ABCCEDP will reimburse for Pap smear after a hysterectomy if: Hysterectomy was due to Cervical Cancer **or if** it was due to Other Reasons and Patient still has cervix.

Indication for Pap Test: Date: _____
- ❑ Screening
- ❑ Surveillance
- ❑ Pap after primary HPV+
- ❑ Pap Test Not Done

Risk for Cervical Cancer:
- ❑ Average risk
- ❑ High risk/increased risk; patient can be screened for annual Pap smear (check all that apply):
  - ❑ Infection with Human Immunodeficiency Virus
  - ❑ Immuno-suppressed (such as those with renal transplants)
  - ❑ Diethystillbestrol (DES) exposure in utero
  - ❑ Previously treated for CIN II, CIN III or cervical cancer found on colposcopic directed biopsy or on a LEEP/cone procedure

Pap Test Result:
- ❑ Negative for intraepithelial lesion or malignancy
- ❑ ASC-US
- ❑ ***Low Grade SIL
- ❑ ***High Grade SIL
- ❑ ***ASC-H
- ❑ ***Squamous Cell Carcinoma
- ❑ ***Atypical Glandular Cells
- ❑ ***Adenocarcinoma in situ (AIS)
- ❑ ***Adenocarcinoma
- ❑ Unsatisfactory

Pelvic Exam Result: Date: _____
- ❑ Normal
- ❑ Abnormal - NOT suspicious for cervical cancer
- ❑ Abnormal - suspicious for cervical cancer

Indication for HPV Test:
- ❑ Co-Test/Screening
- ❑ Reflex
- ❑ Test not done

HPV Result: **HPV test date:** _____
- ❑ Negative
- ❑ Positive with genotyping not done/Unknown
- ❑ Positive with positive genotyping (types 16 or 18)
- ❑ Positive with negative genotyping (+HPV, but not types 16 or 18)

****Diagnostic work-up planned for cervical dysplasia or cancer** (use ABCCEDP Cervical Diagnostic and Follow-Up Form)

GYN Consult to: _____ **Appt. Date:** _____

Pap Follow-Up per ASCCP Guidelines

Repeat Pap Smear: ❑ **1 year** ❑ **3 years** ❑ **5 years**